ILLINOIS WORKERS' COMPENSATION COMMISSION

REQUEST FOR INVESTIGATION INTO EMPLOYER'S INSURANCE COVERAGE

If you cannot find any information regarding an employer's insurance coverage, please complete as much of this form as possible and send it to the Insurance Compliance Division, 100 W. Randolph St. #8-200, Chicago, IL 60601 (telephone: 312/814-4783 or toll-free 866/352-3033; email: inscompquestions.wcc@illinois.gov; fax: 312/814-5979). We will not give your name to the employer. Please use one form for each employer.

Today's date: _____

Name of employer | Employer's owner/manager | Type of business

Employer's FEIN | Number of employees | Web site address

Employer's telephone | Fax number | Cell phone | Email address

Employer's street address, city, state, zip code

Job site address, city, state, zip code (if different from above)

Vehicles at job site (include make/model/plate#)

Describe above any work injuries involving this employer

Injured employee's name, if applicable | Date of accident | Case number

Your name | Relationship to employer (if any)

Your telephone | Fax number | Cell phone | Email address

Your street address, city, state, zip code

If there is any other information you wish to share, please list it below.